Washington Health Professional Services
PO Box 47872
Olympia, WA 98504-7872

WHPS-3

THERAPIST REPORT

The Washington Health Professional Services Program requires this evaluation of the participant's progress as a condition of compliance with the monitoring program. Please be specific in your answers and return this form to the above address by the due date.

Reporting Period From: To:	Report Due at WHPS Office by the 5th of Each Month

Participant Information

Name _____ Telephone _____

Address _____ City _____

Have you read the contract between the participant and Washington Health Professional Services? ..... ☐ Yes ☐ No

Do you understand the terms and conditions? ..... ☐ Yes ☐ No

Questions or Comments: _____

_____

Treatment Plan _____

How long have you been working with this participant? _____

Type of therapy and program: _____

_____

_____

Therapy goals: _____

_____

Progress to Date

Amount of time licensee spends in therapy: _____ hrs/wk _____ hrs/mo

Participant's progress toward therapy goals: _____

_____

_____

Prognosis of therapy: _____

_____

_____

Estimated length of continued treatment: _____

_____

_____

_____

Family/Partner involvement and/or support in Treatment Program: _____

_____

_____

_____

Other Comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Counselor _____ Date _____

Print Name _____

Name of Agency _____ Telephone _____

Address _____

Please provide the following information the first time the therapist files this report.

Type of Degree _____ Length of Time in Practice _____

License/Registration/Certificate # _____

Certified/Qualified Chemical Dependency Counselor? ☐ Yes ☐ No